ACCESS

Newsletter of the Nebraska Office of Rural Health, Nebraska Department of Health & Human Services, Division of Public Health *and the* Nebraska Rural Health Association for all rural health stakeholders

Issue 56, October 2009

contents

Healthcare reform and realities: a Nebraska perspective

by David Howe

A signature 1990s television ad portraying "Harry and Louise" questioning the need for healthcare reform has found the couple making a return appearance, this time lauding the need for reform.

"Real life stories are beginning to teach all of us (about the need for reform)," Keith Mueller told the Nebraska Rural Health Association in a leadoff address at the Association's annual September conference in Kearney.

The Director of the Nebraska Rural Health Research Center at the University of Nebraska Medical Center was making no predictions about when passage of healthcare reform would happen. But, he outlined key elements of reform and predicted that "payment will be linked more and more to quality (of care)."

Drivers of reform include rising deductibles and higher co-payments, along with a steady rise in premiums that is outstripping wage increases.

Mueller noted that some identify a core of 7 million people among the estimated 47 million uninsured in this country who are simply unable to get meaningful coverage. Mueller thinks that core "far exceeds" 7 million.

Reform in the individual and small employer markets is among key elements in proposed legislation, according to Mueller. That encompasses factors such as guaranteed policy renewal, not being denied coverage for pre-existing conditions, and non-cancellation of policies.

Other key elements, he said, are:

- Subsidies for low income households.
- Enhancing workforce supply and addressing maldistribution of workforce. (UNMC's Nebraska Center for Rural Health Research released its final report in mid-September on a study of and strategy for Nebraska's Health Workforce needs, which can be found at www.unmc.edu/rural/documents/NebraskaWorkforceProjectFinal091509.pf).
- Innovations in service delivery (improving quality of care and cost savings through healthcare information technology and care management).
- Changes in Medicare and Medicaid programs, such as raising the income level for Medicaid eligibility.

Mueller listed the following areas where there appears to be consensus on healthcare reform:

- Access to affordable insurance for the uninsured.
- Improved cost-effectiveness in healthcare.
- Reach underserved areas.
- Meet workforce needs.

Mueller noted that healthcare reform legislation is coming through three separate house bills and two in the Senate. On the House side, the three bills have been combined into one piece of legislation known as HR 3200 or the "Tri-Committee bill." On the Senate side, two bills have been combined. The combined House and Senate bills stop next at Conference

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Committee in which differences between the House and Senate versions undergo resolution and reconciliation before going to a vote in the full House and Senate and, if passed, to the President for his signature.

Along the way a number of amendments will be added, Mueller explained.

He made no predictions about when or what kind of legislation would come before the President for signature.

A couple of the several hot points Mueller mentioned was federal expenditures over the next 10 years, "a measure of Federal Government cost, not total net costs," and the so-called public option. The public option in HR 3200 is not "Medicare-like," according to Mueller.

In what Mueller called a "rural roadmap" under healthcare reform, he said: "I would argue strongly that what we need is to put people first." Quality, workforce expansion and incentives for distribution of workforce to better serve rural areas are part of that roadmap. That map includes sustaining success and building on that success, he said, citing critical access hospitals as an example.

Incentives to serve in underserved areas through such efforts as telehealth and comprehensive workforce approaches will help sustain that success he added. (One of the titles in the American Recovery and Re-Investment Act includes incentives for adopting health information technologies such as electronic health records.)

Vigilance in how Medicare payment issues unfold is also important, Mueller noted. "Payment will be linked more and more to quality," he told the rural health conference. ☐

A new model for midlevel professionals

By Gary Ensz, M.D. (guest writer)

At age 57, I was the oldest doctor in a small town in rural Southeast Nebraska. I had 30 years of experience, had accumulated four partners, and had more leisure time than ever before. Our family practice had stopped delivering babies ten years earlier so that stress was gone. I enjoyed seeing patients in our office more than ever. My income was more than that of most of my F.P. colleagues in Omaha and Lincoln. Yet I was contemplating leaving all this for an end of career eight-to-five position.

Why? The same practice obligation that is the deal breaker for many middle-aged F.P.'s—**E.R.Call.** I was simply tired of the early morning calls forcing me to abandon my comfy bed for the bright lights of the E.R. room—often it was to examine a fussy toddler with a fever who was snoozing in mother's arms by the time of my arrival. Or worse yet was being summoned in the wee hours for a two car pile-up with post prom teens that you had delivered almost two decades earlier.

A year ago this all changed. The arrival of a **PEERist** in Auburn, Nebraska rejuvenated my career. PEERist is an acronym for **P**hysician **E**xtender **E**mergency **R**oom Hospital**ist** -- a new health provider model added to our practice.

Emergency Room Physicians have been around for a long time. Every big city hospital is staffed by physicians working eight to 12 hour shifts. Increasingly, smaller town hospitals the size of Beatrice (10,000 population) have become staffed by physicians often just working 24-hour shifts due to lower practice volume.

A town the size of Auburn (3,200 population), however, just doesn't have the numbers to be able to support outside physician E.R. coverage. That responsibility has always fallen to the local physicians, often linked to their local hospital responsibilities and admitting privileges.

Enter the PEERist. This hybrid midlevel health provider has been able to bridge the gap between rural Nebraska and big city medicine. A PEERist works exclusively in the hospital and has no responsibility in our

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office. He/she can be a physician assistant or a nurse practitioner and is employed by the physicians rather than the hospital.

The PEERist has two areas of responsibility. First he/she is responsible for the E.R.; and second he/she is responsible for the hospital inpatients. Hence the term PEERist. This is done under the supervision of a physician.

Our E.R. averages seven patient visits per day and our 20-bed Critical Access Hospital averages a daily census of less than five patients. This allows time for the PEERist to primarily see all of the E.R. visits and manage the hospital service under the supervision of the on-call physician.

A work shift is 48 to 72 hours, and the typical PEERist leaves the shift well-rested. Right now the schedule rotates through a three-week cycle where the PEERist works Monday and Tuesday; then is off for nine days straight; then works Friday through Sunday; then is off two days; then works Wednesday and Thursday and then is off three days only to start the work cycle again the next Monday.

So, after a year and a half, how has the PEERist program worked in Auburn?

1. The PEERists are happy. Our three Physician Assistants are highly qualified veterans who have left other jobs to work for us. With the shift structure it is not a necessity that they live in Auburn and in fact none of them do. The all look at their current jobs and PEERists to be challenging and economically and professionally rewarding.
2. The hospital administration is happy. Our administrator has seen this program as an innovation to keep our hospital strong and retain physicians. Since our hospital is a rural Critical Access Hospital, a lot of the expenses can be recaptured. Nemaha County Hospital's bottom line is healthier than ever and a hospital remodel project is presently underway.
3. The nursing staff and ancillary care professionals are happy. There is a well-qualified PEERist on site 24/7 with a physician back-up immediately available.
4. Patients are happy. They have quicker access to a health professional in the E.R. Hospitalized patients and their families have immediate access to the PEERists.
5. The physicians are happy. We are able to provide better care to our patients increasing from five to eight full-time health care providers in our community of 3200. I no longer have the anxiety of needing to be in my office seeing patients and at the hospital seeing emergencies at the same time. Also, the 3 a.m. phone calls have markedly decreased. When I do get one it's usually from the PEERist who has already evaluated a serious situation and needs another set of hands or my opinion.

Most importantly the PEERist model offers a significant step forward in rural health care delivery. It will allow older physicians to practice longer and allow younger physicians to be recruited to rural areas having PEERists.

For more information, contact Dr. Gary Ensz at grensz@hotmail.com ☐

MARK YOUR CALENDARS

Nebraska Rural Health Advisory Committee
November 6, 2009 - 1:30 p.m. - Lincoln, NE

NRHA Minority and Multicultural Health Conference
December 9-11, 2009 - Memphis, TN
www.RuralHealthWeb.org

NRHA Policy Institute
January 25-27, 2010 - Washington, DC
www.RuralHealthWeb.org

2010 National Rural Health Association Annual Conference
May 18-21, 2010 - Savannah, GA

2010 Annual Nebraska Rural Health Conference
September 16-17, 2010 - Kearney, NE
www.RuralHealthWeb.org

A new care model for Nebraska

What can be done to help improve the health of pregnant women or newborns? A new Rural Outreach Grant award will use an approach that will bring both prenatal and new parent education into the home allowing for improved outcomes through education and early referral. The award will serve pregnant women and newborns residing in Boone, Butler, Colfax, Nance, Platte, Polk, Seward and York Counties. Overall goals of the project are:

1. Reduce preventable safety risks through assessment and education and reduce disparities in available prenatal/postpartum education related to language cultural and distance barriers.
2. Reduce incidence of complications related to baby blues, including postpartum depression and family anxiety and stress through early detection screening using the Quick Psycho-Diagnostic Tool (QPD) and early referral to existing community resources.
3. Establish and then evaluate the effectiveness of a home visitation program in improving birth and postpartum outcomes and to expand that program to all eight counties serviced by year three.

The HRSA (Office of Rural Health Policy) Outreach award of $375,000 is being given to a consortium consisting of the Good Neighbor Community Health Center, Four Corners District Health Department, and Columbus Community Hospital Healthy Families Nebraska Program.

Money from the HRSA Outreach award will specifically go towards: 1. providing in-home education by nurses to peri-natal families related to newborn care, child development, safety, and transportation casts related to provision of these services, 2. Assessment of risk factors for both the newborn and family including physical, developmental and behavioral health issues, 3. Training and ongoing technical assistance of staff (nurses) who will provide services in each of the eight counties served. Money will also be used to support services being offered in both a culturally and linguistically appropriate manner to address the underserved population of Hispanic mothers, newborns and families through support for Spanish-speaking interpreters.

For additional information, contact: Rebecca J. Rayman, 2282 East 32nd Avenue, Columbus, NE 68602, email: rrayman@ecdhd.com or Heather Elton, 2283East 32nd Avenue, Columbus, NE 68602, email: helton@ecdhd.com. ☐

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2. Make a realistic assessment of what resources will be needed by all retirees
3. Look at the resources your community/area presently does have to serve this group and what is needed?
4. Identify new partnerships needed to ensure that your area is inviting this new group of citizens
5. Help in the recruiting of health care professionals candidates who are interested in serving rural Nebraska. Begin a recruiting campaign to welcome retirement-age Boomers to our state and your community.
6. Create a local, specially focused, community development entity to provide a sustainable focus on this emerging population shift issue.

Research is now telling us that people are moving to areas for quality of life issues rather than just career issues. (Businesses are also beginning to move themselves to the locations where their workers want to live.) I believe this is especially true for early retirees and near retirement age citizens. The time to plan is now and the time to act is soon. Let's not miss this opportunity. ☐

Rural Comprehensive Care Network workforce development grant update

by Renee Bauer

The Rural Comprehensive Care Network (RCCN) along with its partners, the Southeast Nebraska AHEC and CIMRO of Nebraska, are in the process of implementing an Outreach grant to create a workforce development program. Grant funding was awarded through the U.S. Department of Health and Human Services (HRSA) Office of Rural Health Policy. The workforce development program will implement strategies to recruit and retain patient care workforce to our member organizations in rural Nebraska. The Workforce Development Program Manager is Renee Bauer. Within the next few months she will be contacting and meeting with healthcare providers in the region to prioritize their individual needs in the workforce.

The Southeast Nebraska AHEC will continue to work with young people to encourage a healthcare career choice. CIMRO of Nebraska will be responsible for evaluating the program and assuring the specified needs are being met.

The workforce program has two priority goals. 1. To increase the number of patient care professionals that choose to be employed by network members. 2. Decrease the turnover rate at network facilities. The program will utilize several strategies to accomplish its goals. We will enhance our partnerships with the regional Educational Institutions, encouraging students to choose healthcare careers and in turn to choose careers with our Network members. We will seek partnerships with Chamber of Commerce, Community Development and Economic Development organizations to assure continued quality of life standards and amenities in our rural communities in order to better recruit healthcare professionals to our communities.

Another key strategy will be retention of the current patient care professionals that are employed in our communities. The team will be offering current patient care professionals educational opportunities to strengthen their skills along with improving their satisfaction with their employers.

Healthcare professionals are seen as key executives in the communities they live and work in. They contribute to and enhance the quality of life in their communities. Healthcare organizations are often overlooked economic drivers for the communities they are located in. Through the workforce development program we will bring healthcare employment into a higher profile occupational choice thus increasing the number of students choosing healthcare occupations and choosing to practice in our rural communities.

Questions about the workforce development program can be directed to Renee Bauer at 1-888-917-3772, ext 6. ☐

Some Nebraska EMS history

Forty years later, the idea to try to train first responders in Kearney still seems like a good one.

From the fall of 1969 to the spring of 1970, 20 men signed up to take the emergency medical care course. The class was a test run of sorts, challenging its students with work in the emergency department and in surgery, as well as first responders in their local community. They also attended weekly class sessions led by Drs. Kenneth Kimball and Joel Johnson.

After the class's success in Kearney, it was used as a reference point for similar programs used by the national Emergency Medical Technician certification pro¬gram. The Kearney trial made the town one of the first nationally to offer a training course for first responders.

"After everyone saw that you could take a guy and turn him into a first responder, it just spread like wildfire," said Johnson, according to the Kearney Hub.

Members from the original class gathered in late May for a lunch and open house in their honor. The event was full of reminiscing of stories about the thousands of calls they took and the countless instances of when they were able to help those in need.

Though students had to take an

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Nebraska Rural Health Association presents awards for outstanding rural health achievement

Awards for Outstanding Rural Health Achievement were presented at the 2009 Nebraska Rural Health Association held in Kearney, NE September 17, and 18, 2009. The Nebraska Rural Health Association takes pride in recognizing individuals who take leadership roles and who make a difference in healthcare in rural Nebraska.

"There are a few things more gratifying than the approval and recognition of our peers for a job well done," said Kim Engel Nebraska Rural Health Association president. "That's why it is an honor to recognize these people for their work in the rural healthcare field." 2009 award recipients were:

President's Award – Dr. David Brown, UNMC College of Dentistry, Lincoln, NE

Outstanding Rural Health Practitioner Award – Dr. Timothy D. Blecha, Family Medical Center, Superior, NE

Outstanding Rural Health Practitioner Award – Dr. Charles Nowacek, Mary Lanning Memorial Hospital, Hastings, NE

Outstanding Rural Health Achievement Award – Greg Schieke and CIMRO of Nebraska, Lincoln, NE

The President's Award. This year the award was presented to Dr David Brown. Dr. David Brown is Professor and Executive Associate Dean at the College of Dentistry. David has been a strong leader in all our outreach and service learning initiatives, and his passion and energy for serving the underserved in rural communities is exemplary. Over the past ten years, the College of Dentistry has made great strides in serving as a resource for improving the oral health of rural Nebraskans. David has been the key player in organizing and managing many of the details of various programs which have lead to our ability

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Veterans hotline and online chat

With Help Comes Hope

Are you in crisis? Please call 1-800-273-TALK

Are you feeling desperate, alone or hopeless? Call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255), a free, 24-hour hotline available to anyone in suicidal crisis or emotional distress. Your call will be routed to the nearest crisis center to you.

- Call for yourself or someone you care about
- Free and confidential
- A network of more than 140 crisis centers nationwide
- Available 24/7

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examination to be certified in 1970, Johnson said there was a greater life lesson to take away from the class experience. "It taught skills, but you have to have the mental capacity to execute those skills under stress," Johnson said. "You couldn't be fearful of being wrong. It was the quality of the individual that could just do it."

Though the backgrounds of each individual in the course varied – greatly, in some instances – Johnson recalled that one common thread was that each person had to balance time between their other jobs, their families and the class.

"It's a whole family commitment to what these guys did then and what they still do today," Johnson said.

For more information on Nebraska EMS activities, contact the State EMS Office at (402) 471-0790. □

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to better serve those communities.

Outstanding Rural Health Practitioner Award. This year the Nebraska Rural Health Association decided to honor two individuals. This award recognizes individuals who are a direct service provider and who have exhibited outstanding leadership, care, and collaboration in improving health services in rural Nebraska. Those eligible for this award are individuals who provide direct patient care.

Dr Timothy Blecha – This year the first Outstanding Rural Health Practitioner Award was presented to Dr Timothy Blecha of Family Medical Center in Superior, NE. Dr Blecha has committed his entire career to his community, raising a family in Superior and dedicating his free time to better the lives of its residents.

Dr Blecha is committed to improving healthcare in his area. He is one of the two physicians that established the Superior Family Medical Center in 1982. The Clinic has since expanded and now employs three doctors as well as three mid-levels. He was instrumental in establishing two satellite clinics. Through his leadership abilities, the clinic is able to serve residents of Nuckolls, Webster, Clay and Thayer counties in NE and Jewell and Republic counties in Kansas.

Dr Charles Nowacek – The second award went to Dr Charles Nowacek of Hastings, NE. Dr. Nowacek exhibits outstanding leadership in bringing and improving health services to rural Nebraska, Dr. Nowacek has practiced medicine for 39 years of which 22 years have been in a rural setting. His patients not only span the outreach of 80 of Nebraska's 93 counties including the majority of Kansas (Mary Lanning outreach patient service area), but also impressively include patients from Iowa, Colorado, California, Indiana, Ohio, Oklahoma, New York and Texas.

While his medical leadership which includes providing surgical spine care via new inter spinus procedures as well as Arthroplasty and the X-Stop, Dr. Nowacek is the only known physician/orthopedic surgeon in Nebraska to incorporate with his spinal care, the acceptance of multidisciplinary care and teamwork extended to Chiropractic Care, Alternative Medicine discipline including Homeopathy, Oriental Chinese Medicine principles, Acupuncture, Nutrition, Yoga exercises, Martial Arts and techniques in Physical Therapy.

Outstanding Rural Health Achievement Award. This award recognizes individuals for leadership and noteworthy initiative in promoting the development of community-oriented, rural healthcare delivery.

This year the award was presented Greg Schieke and CIMRO of Nebraska in Lincoln, Nebraska. CIMRO of Nebraska has served as the Medicare Quality Improvement Organization for the state of Nebraska since February 2003. Under contract with the Centers for Medicare & Medicaid Services (CMS), CIMRO of Nebraska works with healthcare providers throughout Nebraska to improve the quality of care delivered to Medicare beneficiaries.

Technical assistance, educational opportunities and quality improvement expertise are offered to physicians and staff in hospitals, nursing homes, homecare agencies, managed care organizations and physician offices to improve quality through system and process changes. CIMRO of Nebraska has had the honor of working with every Nebraska hospital to improve the quality of care provided, and almost all Nebraska nursing homes and home care agencies.

The impact of CIMRO of Nebraska's efforts has been evident throughout the rural areas of our state through collaborative work, electronic health record implementation, initiatives to improve surgical safety, and efforts to ensure that patients are safe and receive adequate and appropriate care.

The Nebraska Rural Health Association is a non-profit membership organization whose primary mission is to work for the improvement and preservation of rural health in Nebraska. The Association is committed to providing leadership on rural health issues through advocacy, communication and education. The Association provides a statewide forum to address rural health concerns and develop and promote effective solutions at the local, state and national levels.

Next year's conference will be in Kearney on September 16-17, 2010. For more information, contact: Melissa Beaudette, Nebraska Rural Health Association, mbeaudette@mwhc-inc.com ☐

Nebraska workforce study sounds alarms

by Dave Howe

Two of the alarm bells sounded in a recently completed 2-year healthcare workforce study are: 1. a shortage of healthcare professionals, especially in rural Nebraska areas, and 2. a high proportion of these professionals approaching retirement age.

The projected shortages may actually be underestimates, depending on whether healthcare reform efforts result in increased demand for healthcare services, said Dr. Preethy Nayar, M.D., Ph.D., in the Health Services Research Administration at the University of Nebraska Medical Center. She directed the study, which was headed by Dr. Keith Mueller, Director of the Nebraska Center for Rural Health Research in the College of Public Health at UNMC.

The 2-year study, initiated in 2007, is based on data collected on about 30 healthcare professions over a 10-year period. It measured the supply of healthcare professionals in the state, assessed the need for current healthcare professionals, and projected future needs for those professionals.

Following are some of the highlighted findings that appear in the 202-page study report Executive Summary titled, "A Critical Match" (Nebraska's Health Workforce Planning Project." (The full text of the study report can be found online at www.unmc.edu/rural/documents/NebraskaWorkforceProjectFinal091509.pf)

- For most health professions, the ratio of providers per 100,000 population in Nebraska is comparable to that of the rest of the nation. However, the number of providers per 100,000 falls below the national average for physicians, nurse practitioners, nurse anesthetists, certified nurse midwives, chiropractic physicians, and podiatrists.
- Forty-two percent of Nebraska's population lives in rural (non-metro) areas. Yet, only 27.8% of the MDs are practicing in rural areas. The pattern in rural areas is similar for DOs, 33.6%; physician assistants, 38%; RNs, 34.6%; nurse practitioners, 32.6%; dentists, 35.6%; dental hygienists, 32.5%; pharmacists, 37.3%; primary care MDs, 37.4%; psychiatrists, 18.7%; and psychologists, 24.8%.
- Fifteen of Nebraska's 38 frontier counties (counties with 7 or fewer people per square mile) have no healthcare provider for almost all categories of health professionals. Fifty of the state's 93 counties are currently federally designated primary care Health Professional Shortage Areas (HPSAs). *[The Nebraska Office of Rural Health has broken that figure down to the following: 26 counties or parts of counties that are geographic HPSAs, 22 counties that have facility HPSA designations, and 2 counties that have medically underserved population (MUP) HPSA designations. In those counties with facility HPSA designations, only the facilities are eligible for federal aid programs. For more information, contact Marlene Janssen at 402/471-2337]*
- Nearly 30% of the physicians in Nebraska are 55 or older. Percentages of other health professionals in that age category are dentists (39.3%), psychiatrists (36.7%), nurse practitioners specialized in psychiatry (42.9%), physician assistants specialized in psychiatry (33.3%), psychologists (45.2%), and other behavioral health professionals (40.7%), including licensed mental health practitioners, licensed alcohol and drug counselors, certified compulsive gambling counselors, and master social workers.
- The aging pattern is more pronounced in Nebraska's rural areas, where 32.3% of physicians are 55 or older. Nearly a third (32.2%) of pharmacists, 44.4% of dentists, 42.9% of psychiatrists and 50% of nurse practitioners specialized in psychiatry in rural areas are 55 or older.
- All of Nebraska's counties except Mental Health Catchment Area 6 that includes Cass, Dodge, Douglas, Sarpy, and Washington

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health HPSAs.

The third phase of the UNMC workforce study includes projected supply shortfalls for several healthcare professions in Nebraska. Demand for physicians in Nebraska by 2015 is projected at 5,061, 187 more than estimated supply of 4,874, a 3.84% shortfall. But, that gap is estimated to narrow to 32 or less than a 1% shortage by 2020.

The supply of registered nurses will fall short of demand by 3,600 nurses or 20% by 2015 and 5,300 or 26% by 2020, according to a 2008 study commissioned by the Nebraska Hospital Association and cited in the UNMC report.

Nebraska Center for Nursing estimates, also cited in the UNMC report, show somewhat different figures: a shortfall of 18,567 nurses, or nearly 12%, by 2015 and 3,838 or nearly 19% by 2020.

Chiropractic physician numbers are expected to stay fairly constant in the future. There will be 515 professionals in 2010, and the expected numbers for 2015 – 521, 2020 – 525, 2025 – 528, based on present study data.

For a number of health professions, projected demand in the UNMC study was based on health professionals-to-100,000 population and the state's projected population, with those projections in 5-year increments from 2010 to 2025. But, trend data on supply wasn't available, which precluded projections of future shortages or surpluses, according in the UNMC report's authors. Projected demand for these health professionals are shown in the accompanying table.

The fourth and final phase of the 2-year study involves developing a strategic plan to address Nebraska's future health workforce needs. That discussion revolves around workforce development activities in Nebraska, including training, workforce supply, recruitment and retention programs in the state and solutions to workforce development based on evidence from other states.

In a meeting last June, stakeholders were asked to examine barriers to and opportunities in workforce development efforts. That group's input was incorporated into final recommendations for addressing workforce development needs.

The group reached the following summary statement, which grew out of the Nebraska Health Workforce Planning Project: "Nebraska should act now on current healthcare workforce needs and on future projections, particularly because of the mal-distribution of the workforce and expected growth of the elderly population and coverage of the uninsured."

Here are the final recommendations coming out of the project which include the stakeholders' input:

- Create a state health workforce center.
- Support targeted ongoing data collection to monitor the health workforce and future requirements.
- Support an enhanced focus on interdisciplinary, team-based approaches aimed at both education and the provision of services.
- Proactively address health provider shortages and mal-distribution at the state level through the development of comprehensive health workforce criteria and shortage designations.
- Expand the role of pipeline programs aimed at provider shortage areas and primary care.
- Increase funding for current debt relief programs aimed at new graduates.
- Establish new, and streamline existing, community partnerships aimed at health workforce development.

The recommended State Health Workforce Center might be the agency that would logically continue to collect ongoing health workforce data to track changes that impact workforce needs, according to Nayar. Whether such a center would be created, where it would be created, and what its responsibilities would be is a matter for the Legislature, she said. "Our job is to give them (policy makers) the information" on which to base such decisions, she added. ☐

UNMC - Professions Workforce Projections

Health Profession	2010	2015	2020	2025
Nurse Practitioners**	761	769	775	779
Dental Hygienists**	1,035	1,046	1,054	1,060
Physician Assistants**	593	599	604	607
Chiropractic Physicians*	515	521	525	528
Podiatrists*	108	110	111	111
Optometrists*	372	376	379	381
Pharmacists**	1,687	1,706	1,719	1,729
Psychologists*	593	600	604	608
Psychiatrists**	150	152	153	154
Physical Therapists**	1,381	1,396	1,407	1,415
Occupational Therapists**	764	772	778	783
Speech Language Pathologists & Audiologists**	691	698	704	708
Respiratory Care Practitioners**	1,286	1,300	1,310	1,318
Medical Radiographers**	1,984	2,006	2,022	2,033
Medical Nutrition Therapists**	488	494	498	501

*Based on 2004 national average ratio (New York Center for Health Workforce Studies, October 2006, NY Workforce Report); U.S. Census Bureau Population Projections.
**Based on 2007/2008 current Nebraska ratio (Health Professions Tracking Service, University of Nebraska Medical Center, 2007 and 2008, and Nebraska Department of Health and Human Services, 2008); U.S. Census Bureau Population Projections.

Unprecedented global aging examined in new Census Bureau report commissioned by the National Institute on Aging

The average age of the world's population is increasing at an unprecedented rate. The number of people worldwide age 65 and older is estimated at 506 million as of midyear 2008; by 2040, that number will hit 1.3 billion. Thus, in just over 30 years, the proportion of older people will double from 7 percent to 14 percent of the total world population, according to a new report, "An Aging World: 2008."

The report examines the demographic and socioeconomic trends accompanying this phenomenon. It was commissioned by the National Institute on Aging (NIA), part of the National Institutes of Health, and produced by the U.S. Census Bureau. It was released by the Census Bureau.

"The world's population of people over age 65 is growing rapidly, and with it will come a number of challenges and opportunities," said NIA Director Richard J. Hodes, M.D. "NIA and our partners at Census are committed to providing the best data possible so that we can better understand the course of population aging and its implications."

"An Aging World: 2008" examines nine international population trends identified in 2007 by the NIA and the U.S. Department of State. It contains detailed information on life expectancy, health, disability, gender balance, marital status, living arrangements, education and literacy, labor force participation and retirement, and pensions among older people around the world.

"Aging is affecting every country in every part of the world," said Richard Suzman, Ph.D., director of NIA's Division of Behavioral and Social Research. "While there are important differences between developed and developing countries, global aging is changing the social and economic nature of the planet and presenting difficult challenges. The fact that, within 10 years, for the first time in human history there will be more people aged 65 and older than children under 5 in the world underlines the extent of this change."

For more information, please contact: Barbara Cire, (301) 496-1752, nianews3@mail.nih.gov ☐

Rural hospitals face steep curve on health information technology

by Dave Howe

Critical Access Hospitals need to get on board with interoperable electronic health records or risk being pushed to the sidelines. And, Federal stimulus money can help them do that. However, small, rural hospitals face challenging requirements in qualifying for the incentives.

That was the message from Tim Size at the annual Nebraska Rural Health Association conference in Kearney last September. The incentives for implementation of electronic health records (EHRs) come under the Health Information Technology title in the Federal stimulus package, known officially as the 2009 American Recovery and Re-investment Act (ARRA).

Size is executive director of the Rural Wisconsin Health Cooperative (RWHC), which includes 35 rural hospitals, 28 of them critical access hospitals (CAHs). RWHC promotes regional collaboration for health and healthcare services on behalf of rural communities in Wisconsin. Its hospitals are in various stages of implementing EHRs.

Size explained that health information technology (HIT) incentives in ARRA are aimed at giving 70% of Americans interactive/interoperable electronic health records (EHRs) within 5 to 10 years. And, Medicare is the vehicle through which the stimulus package delivers those incentives for adoption of EHRs.

The problem, though, is that the currently proposed schedule of EHR implementation to qualify for incentives is too aggressive for small, rural hospitals, including CAHs, Size said. Under the proposed schedule of adoption, those hospitals will be required to accomplish a level of implementation by 2011 that they can't reasonably be expected to reach until 2015, according to Size.

Yet, he said, adoption of EHRs "couldn't be more critical. It's one of the highest priorities," even without ARRA's incentives, he said, adding: "Critical Access Hospitals will be seen as backwards, if they don't get on board with EHRs."

Incentives could typically be worth $600,000 to $700,000 to a CAH, according to Size. "But, don't do crazy stuff to grab the incentives. Don't let yourself be pushed too fast," he advised. The cost of mistakes in implementing EHRs could "dwarf" the incentive, he added. Be sure, for example, that a vendor's product will lead to "meaningful use."

"Meaningful use" is one of two key terms around which qualification for incentives revolves. The other is "certified EHR expenses." Definitions of what a certified EHR expense is and what constitutes meaningful use are still being ironed out. The direction those definitions ultimately take could have significant impact not only on how challenging it will be for a CAH to achieve meaningful use that qualifies for the incentive, but also the value of the incentive, according to Size.

Final definitions are expected from the Office of National Coordinator (ONC) for HIT in the U.S. Department of Health and Human Services by the end of the year.

Under the HIT title in the stimulus package and the currently proposed schedule of adoption for the incentives, CAHs that are meaningful users by 2011 are eligible for 4 years of enhanced Medicare payments (20% over Medicare Share with charity adjustment) with immediate full depreciation of certified EHR costs, including undepreciated costs from previous years," Size said in his health conference presentation. CAHs must become meaningful EHR users in stages between 2011 and 2015, after which penalties kick in for non-adopters, he said.

Only un-depreciated EHR expenses qualify for the incentives in the case of CAHs. Depreciated EHR expenses by early-adopter CAHs are not eligible for incentive payments, Size emphasized. Those are the costs depreciated before 2011. Consequently, a CAH attempting to maximize its incentive has to shoot for leaving as much of its certified EHR expense undepreciated as possible by time it reaches meaningful user designation, according to Size.

By contrast, prospective payment system (PPS) hospitals that become meaningful users by 2013 qualify for incentives, regardless of their costs or timing of their EHR costs prior to 2015, Size said. Penalties for non-adopter PPS hospitals begin in 2015, as is the case for CAHs.

Physicians who are meaningful users receive 75% of estimated allowed charges limited to $15,000 in year 1, $12,000 in year 2, $8,000 in year 3, $4,000 in year 4, and $2,000 in year 5 with year 1 incentive increased to $18,000 if they first adopt in 2011 and 2012, Size said.

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HIT *cont'd from p. 11*

Size expanded on why he believes the bar has been set too high for small and rural hospitals to become meaningful users before 2015. Those hospitals aren't as far along with implementation of EHRs as larger urban hospitals. Therefore, they have further to go than their larger counterparts in reaching meaningful use by the deadlines set out in the legislation. And, the proposed schedule of adoption for the incentive makes no distinction between small, rural hospitals and their larger counterparts.

He explained his views by pointing to an EHR adoption model. That model breaks down EHR capabilities into eight stages as shown in the accompanying table. The stages, developed by the Healthcare Information Management Systems Society (HIMSS), show that the median EHR adoption rate score is 1.0860 for CAHs, while the median score is 2.2820 for general medical/surgical hospitals and 3.2520 for academic/teaching hospitals.

Current HIT Policy Committee recommendations for meaningful use by 2011 is roughly a score of 4.0 on the HIMSS scale at that time. Size said "it is unclear, if not unlikely, they (committee recommendations) are achievable" by providers who are currently at 1.0 or lower on the scale.

He thinks the HIMSS adoption model stages will probably remain essentially unchanged from what they are now.

In a paper published by the RWHC on the stimulus incentives for health information, the cooperative stated: "We believe it would be reasonable to move CAHs and small rural hospitals to above stage 2 in 2011; then above stage 3 in 2013; and then to roughly stage 4 in 2015."

One particular concern for meeting Stage 4 by 2011 to qualify for the incentives is computerized physician order entry (CPOE) and patient portals. Those are advanced applications that come only after a number of other applications must first be in place, the RWHC states in a paper it has published about its concerns over requirements that small, rural hospitals will have to meet for the HIT incentives.

Size listed a number of strategies for rural providers to consider in their quest for becoming meaningful users and qualifying for EHR implementation incentives. Among them:

- Focus on improving workflow and quality.
- Invest in someone capable of leading the charge.
- Use consultants strategically, without creating a dependency relationship.
- Bend over backwards to involve physicians in selecting the systems that will impact them.
- Provide non-threatening forms for stakeholders to discuss resolution strategies.
- Recognize that Interdepartmental cooperation and communication are critical in an EHR environment.
- Pursue cost-effective strategies, but make sure they will lead to the goals of meaningful use.
- Consider collaborative opportunities.

Vendor selection is critical, Size said. He recommended a couple of websites for guidance on choosing a vendor. They are:

www.cchit.org/choose/inpatient/2007
www.cchit.org/choose/ambulatory/08

And, he mentioned the following two online toolkits for rural providers in the process of implementing EHRs: **www.stratishealth.org/expertise/healthit/hospitals/index.html** and **http://healthit.ahrq.gov/**

HIMSS EHR Adoption Model

Stage	Cumulative Capabilities
0	Laboratory, radiology & pharmacy not installed
1	Laboratory, radiology & pharmacy all installed
2	Clinical data repository, controlled medical vocabulary, clinical decision support system (CDSS), may have document imaging
3	Clinical documentation (flow sheets), CDSS (error checking), PACS available outside radiology
4	Computerized physician order entry, CDSS (clinical protocols)
5	Closed loop medication administration
6	Physician documentation (structured templates), full CDSS (variance & compliance), full R-PACS
7	Medical record fully electronic; ability to contribute continuity of care document as byproduct of electronic medical record; data warehousing in use.

HIMSS (Healthcare Information and Management System Society)

UNMC announces new scholarship for northeast Nebraska nursing students

by Jo Giles, UNMC

A new scholarship -- providing tuition, fees and a living stipend -- is available for students in northeast Nebraska who are interested in a nursing career. The University of Nebraska Medical Center (UNMC) Excellence Scholarship is designed to develop nurses who want to teach nursing.

"There are not enough nurse educators to teach the next generation of students and provide critical care to patients across Nebraska. This scholarship is the first use of a community fund designed to remedy that," said Ruth Macnamara, Ph.D., associate professor and assistant dean of the UNMC College of Nursing Northern Division, located on the Northeast Community College Campus in Norfolk.

The scholarship would provide UNMC tuition, fees and a living stipend for up to two years and may be extended. It is contingent upon maintaining a GPA of 3.5 and is available to residents of one of the north region counties.

The counties include: Antelope, Boone, Boyd, Brown, Burt, Cedar, Cherry, Colfax, Cuming, Dakota, Dixon, Dodge, Holt, KeyaPaha, Knox, Madison, Nance, Pierce, Platte Rock, Stanton, Thurston, Wayne and Wheeler.

Funding for the scholarship is provided by the Nursing Fund for Excellence, which was established to provide greater student assistance and state-of-the-art equipment. Faith Regional Health Services is a major contributor to the fund, along with hospitals, health agencies and individuals in north and northeast Nebraska.

"The college continues to be impressed with the support it receives from northeast Nebraskans for the new nursing program in the area. This scholarship is the initial step in giving back to the community. More use of the funds will follow during the year prior to the opening of the nursing program and building," Dr. Macnamara said.

The facility, named the J. Paul and Eleanor McIntosh College of Nursing, is scheduled to open in 2010 and will house nursing programs of UNMC and Northeast Community College. A unique public-private partnership made the project possible. Private donations of $11.9 million funded the project and operating expenses will be provided by the state of Nebraska, Northeast Community College (NECC) and federal funds generated by NECC.

Scholarship applications for the 2009-2010 academic school year can be submitted now. Applications for other academic school years will be accepted on a continual basis. The application is available UNMC's College of Nursing website at http://www.unmc.edu/nursing/243.htm. E-mail form to rmacnamara@unmc.edu.

For more information, contact Dr. Macnamara at UNMC College of Nursing Northern Division, 985330 Nebraska Medical Center Omaha, NE, 68198-5330. Or call (402) 253-5515 or e-mail rmacnamara@unmc.edu.

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ACCESSory Thoughts

Dennis Berens, Director
Nebraska Office of Rural Health

Rural is changing
Will we react soon enough?

I just finished reading a new USDA ERS research study called: *Baby Boom Migration and its Impact on Rural America.*

Overall the study noted that the baby boom migration will increase the overall size of rural America's retirement-age population. They predict that the 55-75 year olds will increase two thirds, from 8.6 million to 14.2 million between 2000 and 2020. Between 2010 and 2020 boomers are expected to make more than 200 million residential moves based on trend lines, many to rural areas in America. What could this mean for Nebraska? Will we have places willing to invite and capable of working with the aging boomer and family?

We know that medical and behavioral health care is an area of concern before a move can be considered, especially for retirees. So do we have enough of these services in our rural areas? Can communities work together at growing their populations and providing area service sectors that Boomer retirees will need? What about broadband connectivity at the level Baby Boomers need/want?

The Office of Rural Health has contracted with the Nebraska Rural Health Resource Center at UNMC to do county profiles under the name, Nebraska Rural Health Works. If you go to the web site: http://www.unmc.edu/rural/NeRHW you will find the studies that have been completed including several statewide analyses. Bottom line, health care is a major economic development engine in our state, especially in our rural areas.

Our Office is also the home of the Nebraska Rural Health Incentive Programs that are designed to help communities recruit health care professionals. We expect a heavy turnover of these professionals because many are also Boomers and we will need a large collective effort to recruit providers to our rural and remote areas. So where do we start?

May I suggest the following?

1. Bring your community together to look at what you have to offer to retirees?

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